Fort Bend County Section 125 Plan Year January 1, 2014 through December 31, 2014

Employee Name: _____ SSN: _____
(Please Print Legibly First, Middle, Last Name)

Department Name: _____ Department Number: _____

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TERMS AND CONDITIONS

- Plan participation is voluntary. Every plan year you must ***complete enrollment,*** indicating whether you wish to participate or not to participate.
- Annual elections cannot be changed during the plan year unless there is a qualifying family status change. For changes contact Risk Management within 30 days of the event date.
- Participation in the pre-tax benefits of the plan may reduce your Social Security benefits.
- Your cost for premium dependent benefits elected below will be redirected pre-tax from each paycheck.
- A monthly fee of $1.50 is deducted for participation in each reimbursement account.
- Any money remaining in reimbursement accounts after the 60-day grace period will be forfeited in accordance with current plan provisions and tax laws.
- You may elect reimbursement accounts below to set aside additional pre-tax money to pay for unreimbursed eligible health care expenses not paid by your benefits and for dependent care expenses. You must calculate and fill in the per payroll deduction period amount. This dollar amount will not be filled in for you.
- If you check ***YES*** in any of the below sections, you are hereby electing to participate in the plan and agree to abide by the terms, conditions and limitations of the plan and any separate plans, contracts and documents made a part thereof.
- If electing to participate, I hereby agree to have my gross pay reduced by the amount of the cost of the benefits I elected below and I understand that this amount will not be subject to Social Security or Federal Income Tax Withholding.
- Payroll Frequency*****: Bi-weekly employee - 24 payroll deductions per plan year. Semi-monthly elected official - 24 payroll deductions per plan year. Mid-year enrollment – remaining payroll deduction periods.
- ***NOTE:*** Salary reductions currently in effect ***DO NOT*** automatically continue into the next plan year. You must complete enrollment each year during the scheduled enrollment period. Completion of this form ***DOES NOT*** add and/or change the employee or your dependent(s) enrollment in the Medical, Dental, Vision and/or Optional Benefit Plans. To add and/or make changes to your coverage you must contact Risk Management and complete the appropriate forms.

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A. MEDICAL, DENTAL, VISION AND/OR OPTIONAL EMPLOYEE/DEPENDENT PREMIUMS (rates vary)

Payment with before-tax dollars of the premiums for participation in any of the following plans: Fort Bend County Employee Benefit Plan (Medical), Fort Bend County Employee Benefit Plan (Dental), CompDent (DHMO), VisionCare and eligible Optional Plans.

☐ ***YES***, I elect to have my before-tax salary reduced by any employee/dependent premiums for participation in the Medical, Dental, Vision, and/or eligible Optional Plans.

☐ ***NO***

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B. HEALTH CARE REIMBURSEMENT ACCOUNT

Monthly administration fee for participation is $1.50. Provides for eligible reimbursement with before-tax dollars of certain Medical, Dental and/or Vision expenses incurred during the plan year for which you are not otherwise reimbursed (excluding premiums). There is a $2,500.00 **annual** election limit.

☐ ***YES***, I elect to have my before-tax salary reduced by $_____ per payroll deduction period***** and credited to my Health Care Reimbursement Account. Automatic reimbursement is available only for Fort Bend County Employee Benefit Plan PPO Medical and/or Dental Claims. All other eligible expenses must be submitted for reimbursement with a claim form.

☐ ***Decline automatic health care reimbursement*** - Automatic reimbursement is available for Fort Bend County Employee Benefit Plan (PPO Medical and/or Dental) participants. If you are a PPO participant and you do not want automatic reimbursement, please check this box. All eligible expenses must be submitted for reimbursement with a claim form.

☐ ***NO***

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C. DEPENDENT CARE REIMBURSEMENT ACCOUNT

Monthly administration fee for participation is $1.50. Provides for reimbursement with before-tax dollars of certain employment-related child day care and other eligible dependent care expenses incurred during the plan year. There is a maximum $5,000.00 **annual** election limit for a married individual filing a joint income tax return, and a maximum $2,500.00 **annual** election limit for a married individual filing a separate income tax return.

☐ ***YES,*** I elect to have my before-tax salary reduced by $_____ per payroll deduction period***** and credited to my Dependent Care Reimbursement Account.

☐ ***NO***

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Risk Management Department Authorization Stamp:

Employee Signature: _____ ***Date:*** _____

**** * * Please return original form to Risk Management * * ****